CVS caremark™ {{PANUMCODE}}

Tarceva

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the patient's diagnosis?
   - ❑ Non-small cell lung cancer (including brain metastases from non-small cell lung cancer)
   - ❑ Pancreatic cancer
   - ❑ Chordoma
   - ❑ Renal cell carcinoma
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the patient currently receiving treatment with the requested medication?
   ❑ Yes ❑ No *If No, skip to #8*
4. *If the diagnosis is Non-small cell lung cancer (including brain metastases from non-small cell lung cancer),* has the patient experienced either unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes, unacceptable toxicity ❑ Yes, disease progression ❑ No *No further questions*
5. *If the diagnosis is Pancreatic cancer, Chordoma, Renal cell carcinoma,* is there evidence of unacceptable toxicity or disease progression while on the current regimen? *If Yes, no further questions* ❑ Yes ❑ No
6. Is the disease T790M negative? ❑ Yes ❑ No
7. Has the patient experienced unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No *No further questions*
8. Will Tarceva be used as any of the following?
   - ❑ A single agent
   - ❑ In combination with ramucirumab or bevacizumab
   - ❑ In combination with gemcitabine
   - ❑ In combination with bevacizumab
9. What is the clinical setting in which the requested drug will be used?
   ❑ Recurrent ❑ Advanced ❑ Metastatic ❑ Locally advanced ❑ Unresectable
   ❑ Relapsed ❑ Stage IV

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Non-Small Cell Lung Cancer (Including Brain Metastases from Non-Small Cell Lung Cancer)

10. Does the patient have sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease?
    ACTION REQUIRED: If Yes, attach EGFR mutation test results. ❑ Yes ❑ No ❑ Unknown

Section B: Renal Cell Carcinoma

11. Does the disease have non-clear cell histology? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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